GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Administrative Issuance: CFSA- 09-9

TO: All Staff

FROM: Roque R. Gerald, Psy.D., Acting Director
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DATE: April 13, 2009

RE: Medical Records Maintenance

This administrative issuance offers immediate guidance to CFSA staff and private agency staff with case management responsibilities regarding the maintenance of medical records. The careful maintenance of medical records is critical to the safety and well-being of the children in the care of CFSA. It is essential to maintain these records in an organized format, and have them easily accessible to the assigned social workers, their supervisors, the Office of Clinical Practice-Clinical and Health Services Administration, and others deemed necessary. Medical records should be comprehensive, concise, and contain accurate information and documentation of the child's health history. It is also important that the child's medical records are reviewed and monitored on a routine basis to ensure accuracy of vital healthcare information.

It is the policy of CFSA to maintain the medical records of children in its care according to prescribed Agency standards. The maintenance of medical records – both the physical record and the information recorded in FACES - shall reflect the following:

1. A diligent standard of maintenance that will allow for ease of access to critical health information;
2. A system that has standardized processes yet is flexible enough to account for the unique health situations for each child;
3. A comprehensive health history and health plan for each child, which reflects thoughtful information management;
4. An accurate accounting of the child's past medical history, current health status, and proposed future plan of treatment; and
5. A high standard and respect for individual confidentiality and privacy.

For questions regarding this issuance, please contact the Office of Clinical Practice-Clinical and Health Services Administration.

Standards, Responsibilities, and Activities of Records Maintenance
The primary responsibility of maintaining the child's medical records shall be that of the social worker assigned to the child's case. The assigned social worker shall be responsible for the following case record standards:

1. Documentation of current and past health and medical information and activities for the child in the medical section of the case file record and in the FACES medical screens;
2. Current and past child health and medical information, documents and records;

3. Case records shall contain all pertinent consent forms and a record of the child's health and medical history.

4. Records maintained in an organized format to provide accessible and accurate health and medical information for the care and coordination of healthcare for children.

The Initial Healthcare Record
In the initial healthcare record, the Child Protective Services (CPS) social worker, in conjunction with the Office of Clinical Practice (OCP) nurse, shall:

1. Compile a medical record as a section in the child's case file record, containing all major past and current healthcare and medical activities and information, including a copy of the initial screening documentation, and any treatment plans for on-going healthcare [See Chapter I - Initial Evaluation of Children's Health Policy];

2. Obtain signed consent forms from the child's parent or guardian for the release of past medical records and medical history, if applicable [See Chapter I – Initial Evaluation of Children's Health Policy];

3. Obtain past health records, through written requests, from all known previous and current healthcare providers;

4. Verify health and medical activities of the child through the D.C. Department of Healthcare Finance Medicaid public health records and private providers;

5. Record all medical-related activities, including records and information collection, into the child's case record and FACES; and,

6. Forward all collected medical documentation to the assigned social worker for placement into the child's official case record.

The OCP-Clinical and Health Services Administration is responsible for assuring, in consultation with the assigned social worker, that the healthcare information accompanies the child or youth to the initial EPSDT visit.

Child's Health History
All known information and documentation regarding the child's health and medical history shall be contained in the appropriate medical section of the case file.

1. All collected medical history information, including the child's medical history from all known health care providers and all medical information available from the public health system/Medicaid, shall be documented in reverse chronological order and integrated into the physical case record;

2. All critical information, including the date information is received, shall be documented in FACES;

3. Critical information shall include:

    a. Birth History
    b. Developmental History
    c. Previous/Current Healthcare Providers
    d. Previous/Current Insurance Carrier
    e. Previous/Current Diagnosis
    f. Previous/Current Major Treatment, including previous and current prescription history
    g. History of Hospitalization
    h. Known Drug or Other Allergies.

Monitoring of Medical Records
The supervisor of the assigned social worker shall be responsible for monitoring and reviewing the child's medical records. The supervisor shall:

1. Review the medical status of the child or youth with the assigned social worker during each supervision and ensure that the information is documented in the FACES medical screens.
2. Review case files for agency standards as outlined in Procedures E and F (see below).
3. Request the child's social worker to gather additional health information where deemed necessary.
4. Seek consultation from the OCP-Clinical and Health Services Administration, or request information, where additional information is necessary to ensure prescribed Agency standards.

Content of Electronic Medical Record (FACES)
The electronic record (FACES) will provide current, accessible and accurate information on the child's health. The electronic record shall reflect the following:

1. All recorded electronic progress notes will follow agency standards for structure and content;
2. All collected health and medical information, including date information is received;
3. All healthcare activities, or coordination activities (including staffings, discussion of treatment plans, etc);
4. All agency interactions, which involve the release of private medical information to external providers, including reason for release, and location of Consent for Release forms, when applicable;
5. All transactions involving the consent to treatment [See Chapter VI - Medical Consents Policy];
6. All transactions involving the consent to services, for any reason [See Chapter VI - Medical Consents Policy]; and
7. All information pertaining to the child's current healthcare providers, including current contact information and relationship.

Content of Physical Medical Record
The physical record will provide current and comprehensive health and medical information on the child. The physical medical record shall reflect the following:

1. All relevant medical information, filed in reverse chronological order;
2. All collected documentation from external providers, including medical forms, prescriptions, and any relevant medical documentation;
3. All healthcare activities, or coordination activities (including staffings, discussion of treatment plans, etc);
4. All forms or documentation pertaining to the release of confidential medical information; and
5. All forms or documentation pertaining to medical consent [See Chapter VI - Medical Consents].

Format of Physical Medical Record
All physical records will be organized in the following standard order:

1. A summary of all current and relevant historical information on the child's health should be placed at the forefront of the case file to include the following information:
    a. Client name
    b. FACES identification number
    c. Assigned social worker
    d. Date of Birth (DOB)

e. Height (and date of measurement)
f. Weight (and date of measurement)
g. Gender
h. Primary care healthcare provider (PCP)
i. Contact information for PCP
j. Insurance carrier
k. Insurance Number
l. Medicaid card (or copy)
m. Emergency contact and next of kin
n. Major diagnosis
o. Major treatment (historical or ongoing)
p. History of hospitalization(s)
q. Special notifications/precautions (for children with special needs)
r. Consents for release of information (list of individuals whom Private Health Information may be release to)
s. Known drug or other allergies
t. Other

2. Information on the child's medication history, provided by the child's healthcare provider, shall contain the following:

a. Current medications (including psychotropic medications);
b. Past medications;
c. Dosage;
d. Frequency;
e. Drug allergies;
f. Insurance carrier;
g. Pharmacy;
h. Prescribing physician;
i. Special instructions; and
j. Other significant information.

3. Documents or information collected from healthcare providers and maintained in reverse chronological order, shall include the following:

a. Medical assessment
b. Immunizations
c. Dental assessment
d. Mental/behavioral health screening and applicable assessment
e. Developmental screening and applicable assessment
f. Vision and hearing screening and applicable assessment
g. Substance abuse assessment, if applicable
h. Past medical records
i. Laboratory reports.

4. Pre-placement screening medical records (with the exception of the results of the HIV screening). (See HIV Policy)

5. Consent forms (from the parents and from the child or youth)

6. Other Agency forms and medical notices.

Confidentiality and Health Information
The medical section of the case file should reflect all privacy or sharing transactions including the following:

1. HIPAA forms, signed by parent or legal guardian;
2. Consent for the release of information;
3. Requests for Private Health Information;
4. The release, or receipt, of private health information;
5. Consent to receive treatment; and
6. Any other documentation related to private health information.

All HIV or AIDS related documents must be kept strictly confidential within the CFSA case record. HIV-related medical information (e.g., HIV risk assessment materials, test results, treatment reports) should be maintained in a sealed manila envelope in the medical section of the case record. The envelope must be clearly labeled "Confidential" and instructions should appear on the outside of the envelope as to who may have access to the information. Generally, access will be limited to the social worker, supervisor and program manager or administrator directly responsible for investigating abuse or neglect or for providing or securing care and services for a child or youth or a family. CFSA's Medical Director and nurses, as well as parents, legal guardians and those responsible for the child or youth's daily care shall have access. Additionally, written consent may be obtained from the child or youth that is of an age and mental status to give informed consent, to share information with others such as medical or dental care providers, for specific purposes. [See Healthcare policy, Chapter VII: HIV and AIDS. Social workers shall consult the HIV policy for further criteria regarding the confidentiality of medical information related to a child's HIV and/or AIDS status.]